Client Assessment

Name _____ Initial/Final

Record ID

_____

DATE of Client Assessment

_____

Name of Staff that performed Assessment:

_____
(First and Last Name)

Which assessment is this:

◯ Initial
◯ Final

Weight (lbs)

_____
(lbs 1 decimal places)

Has your doctor recommended a diet for you to follow?

◯ a.Yes
◯ b.No
◯ c. Unsure

What kind of diet?

☐ a. Diabetic/ low carb
☐ b. Heart healthy (low sodium, low fat)
☐ c. Regular/Eat balanced
☐ d. Diet to lose weight
☐ e. Other
☐ f. None

If other, what kind

_____

Do you currently take any

◯ a. Vitamin replacement
◯ b. Meal Replacement
◯ c.None of the above
If yes, please specify

Have you lost weight in the last 3 months?

◯ a.Yes
◯ b.No
◯ c.Unsure

If yes, how many (lbs)

_____

Why did Weight Loss occur?

◯ a. Intentional
◯ b. Due to medical conditions
◯ c. Other
If other, please specify

Your appetite is

◯ a. Poor
◯ b. Fair
◯ c. Good
◯ d. Excellent

How many meals do you typically eat in a day?

_____

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If less than 3, why do you not eat more in one day?	◯ a. Cannot afford ◯ b. Makes me feel ill ◯ c. No way to get to grocery store ◯ d. Just not hungry ◯ e. Too much trouble to fix
Do you eat alone most of the time?	◯ Yes ◯ No
Do you take 3 or more different prescribed or over the counter drugs a day?	◯ Yes ◯ No
Names of medicine	☐ a blood pressure ☐ b. diabetic ☐ c. heart ☐ d. not answered ☐ e. Other If other, please specify
Are you physically able to shop, cook, or feed yourself?	◯ a.Yes ◯ b.No ◯ c.Need assistance
I have	☐ a. Physical handicap ☐ b. Chewing/swallowing problems ☐ c. Other
How often do you use a cell phone, computer, iPad, or timesother electronic device each day?	◯ a. 1-3 ◯ b. 4-8 times ◯ c. More than 8 times ◯ d.None
Do you have a standardized size refrigerator?	◯ Yes ◯ No N/A
I have	☐ a. Dorm size refrigerator ☐ b. No freezer ☐ c. Use cooler ☐ d. Have refrigerator but no freezer ☐ e. Other N/A
In the last three months, how many unplanned doctor's visit did you have?	◯ a. 1-3 visits ◯ b. More than 3 visits ◯ c.None
Reasons for doctor's visits	☐ a. Routine/Wellnes/Annual ☐ b. For medical condition(diabetes, BP, heart disease) ☐ c. Other If other, please specify
Do you also get food from food pantries or other community resources?	◯ Yes ◯ No
I also receive food assistance sometimes from	☐ a. Local food pantries ☐ b. Community provided meals
Do you have any food allergies or food dislikes?	◯ Yes ◯ No N/A

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I have these Food allergies that may cause life threatening reactions	☐ a. Shellfish ☐ b. Wheat ☐ c. Nuts N/A
Medical conditions	☐ a. Diabetes, pre-diabetes ☐ b. Heart disease ☐ c. High blood pressure ☐ d. Cancer ☐ e. Overweight/ Obesity ☐ f. None
Diet Order	☐ a. Diabetic ☐ b. Heart Healthy (low fat, low sodium) ☐ c. Weight Loss ☐ d. Weight Gain ☐ e. Regular
Practicing Hospital of PCP	◯ a. Eskenazi Health ◯ b. Other If other, please specify